type are selected for grafting almost all raw areas, and since both can be cut with this machine, it has become indispensable to the reconstruction surgeon. After nearly two years' experience with the Padgett Dermatome, the author is enthusiastic about its merits and urges that its use be adopted widely.

The illustrations are of the apparatus in use and some of the author's cases showing the grafts.

490 Post Street.

CLINICAL NOTES AND CASE REPORTS

CONGENITAL ABSENCE OF THE PECTORALIS MAJOR*

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PARTIAL absence of the pectoral muscles is not infrequent.[1] Bing[2] estimated that they comprise 28 per cent of cases of congenital absence of muscles. However, Jones[3] believes this figure is too high, maintaining that many congenital absences are not as easily detected as the pectoral group.

Complete absence of the pectoralis major is rare. The usual lesion is absence of the sternocostal portion, with or without absence of the pectoralis minor. The well-developed, curved, anterior axillary fold is absent in these patients, and is only slightly compensated by hypertrophy of any remaining muscle strands. (See figure.) Absence of both major and minor have been reported.[3, 4, 5] Only one case of bilateral absence has been reported.[6]

Associated congenital anomalies of the homolateral hemithorax and upper extremity are quite common. Rib and costal cartilage defects,[7] breast defects, (see figure) syndactylism,[1, 8, 9, 10] shortening of the upper extremity,[7] brachydactylism,[7] absence of external abdominal oblique,[10] partial absence of the serratus anterior,[11] latissimus dorsi,[11] and intercostals[11] all have been reported.

Of the several theories advanced as to the etiology of pectoral defects, the most quoted is that of Lewis.[12] He found that in the 9 mm. embryo the pectoral muscle mass is largely above the first rib. In the 11 mm. embryo it extends lower, but it is still undifferentiated into its component parts, and is not attached to the ribs or humerus. In the 16 mm. embryo, the clavicular portion is split off and the remainder then divides into the sternal portion and the pectoralis minor. Perhaps the failure of the primitive mass to attach itself to the ribs and sternum might allow its not becoming differentiated into its normal component parts. This coincides with the known fact that the defects are usually in the caudal portion.

REPORT OF CASE

This patient is a 24-year old Japanese male, who was seen in the Lung Clinic of the Fairmont Hospital, in San Leandro, because of tuberculosis contact history. He was asymptomatic. Past history and functional inquiry are entirely negative. Family history, according to the patient, reveals no known congenital defects. Physical findings are entirely negative, except for the absence of the caudal portion of the left pectoralis major, and the left mammary gland. No functional impairment is detected clinically. Fluoroscopy and x-ray films reveal a normal bony thoracic cage. Heart and aorta are within normal limits. The lung fields are entirely clear. From the x-ray alone may be gained the impression of a previous left radical mastectomy.

Fairmont Hospital, San Leandro.

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INTRAVENOUS ANESTHESIA: A PRACTICAL METHOD FOR ITS ADMINISTRATION

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MOST anesthetists have developed a technique of their own for the administration of intravenous anesthesia, so that their hands are partially freed. When intravenous anesthesia first became popular, its administration was considered to be a two-man job; one to administer the anesthetic and the other to support the patient's chin and administer oxygen when necessary. Its administration can be simplified by the intermittent injection of the drug directly into the rubber tube of an intravenous infusion, but the routine use of this method is not justified because of its cost. Several ingenious mechanical devices have been developed to simplify the administration of intravenous anesthetic, but none of these are on the open market.

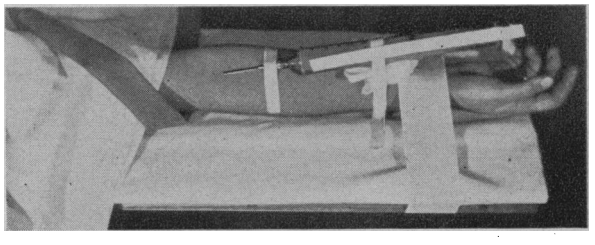

Fig. 1.—Showing application of the method.

* From the Fairmont Hospital, San Leandro.

(Continued on Page 59)

(Continued from Page 18)

The method about to be described is simple, inexpensive and efficient; so simple, in fact, that the same idea must have occurred to others. But there are still those who occasionally find themselves in the embarrassing position of not having enough hands for the many tasks which arise during the course of an intravenous anesthetic, and it is for these that this suggestion is intended.

Four strips of adhesive are prepared before the anesthetic is begun; one strip about 2″ x 18″, and the other three about 1″ x 6″. The first strip firmly binds the patient's arm to the arm-board, and is placed over the wrist so that both flexion and rotary motion of the arm is impossible. After the initial injection is made, a second strip is placed over the hub of the needle to anchor it in place. The third strip is placed along the barrel and plunger of the syringe, to prevent blood from backing up into the solution. The syringe is then elevated, to produce the correct amount of angulation, and supported with a sponge, and the fourth strip of adhesive then binds the barrel of the syringe to the patient's arm.

In this way the syringe is bound firmly to the patient's arm, and the anesthetist can safely leave the syringe from time to time to regulate the patient's airway, administer oxygen if necessary, observe the vital signs and refill his own syringes. The adhesive strip running along the plunger of the syringe can be easily lifted and replaced for injections.

1401 So. Hope Street.

A Surgeon's Prayer in Wartime

God of Battle, grant that the wounded may swiftly arrive at their hospital haven, so that the safeguards of modern surgery may surround them, to the end that their pain is assuaged and their broken bodies are mended.

Grant me as a surgeon, gentle skill and intelligent foresight to bar the path to such sordid enemies as shock, hemorrhage and infection.

Give me plentifully of the blood of their non-combatant fellow man, so that their vital fluid may be replaced and thus make all the donor people realize that they, too, have given their life's blood in a noble cause.

Give me the instruments of my calling so that my work may be swift and accurate; but provide me with resourceful ingenuity so that I may do without bounteous supplies.

Strengthen my hand, endow me with valiant energy to go on through day and night; and keep my heart and brain attuned to duty and great opportunity.

Let me never forget that a life or a limb is in my keeping and do not let my judgment falter.

Enable me to give renewed courage and hope to the living and comfort to the dying.

Let me never forget that in the battles to be won, I too must play my part, to the glory of a great calling and as a follower of the Great Physician. Amen.

Christmas night, 1941.

John J. Moorhead, Col., M.C., in Hawaii M.J. 1:157 (January) 1942.

Diagnosis is to disease what harmony is to music: any discord is fatal.

When the proper technique is patiently pursued the diagnosis makes itself.

Without a correct diagnosis, therapy is blind and often harmful.

INDEX—MINUTES: C.M.A. HOUSE OF DELEGATES

Re: Pages 60 to 107

(Continued from front cover)

MINUTES: HOUSE OF DELEGATES—ANNUAL SESSION, 1942

First Meeting: Monday, May 4 60
Organization of House of Delegates 60
Appointment of Reference Committees 60
Address of President Rogers 61
Supplementary Report of C.M.A. Council (Alameda) 61
Reports of Standing and Special Committees:
(a) Committee on Public Policy and Legislation 62
(b) Committee on Payments for Medical Services 63
(c) Committee on Conference with California State Federation of Labor 64
(d) Committee on Medical Services Rendered by Hospital Associations 64
(e) Committee on Hospital Subsidy 64
(f) Committee on Industrial Accident Fee Schedule 65
(g) Committee on Medical Preparedness 65
(h) Committee on Procurement and Assignment 65
Amendments to the Constitution 66
New Business: Introduction of Resolutions:
(a) Industrial Accident Code 67
(b) Subversive Activities 67
(c) Relation of State Association and Component County Units 67
(d) Relations Between Physicians and Insurance Companies 67
(e) Rebates 67
(f) Physicians' Benevolence Committee 68

Second Meeting: May 6, 1942: Afternoon Session 69
Place of 1943 Annual Session: Hotel Del Monte 69
Election of Officers 69
(a) General Officers 69
(b) District Councilors 70
(c) Councilors-at-Large 70
(d) Delegates to A.M.A. 70
(e) Alternate Delegates to A.M.A. 70
(f) Standing and Special Committees 71
(g) Editorial Board 71

Recess: Evening Meeting: May 6, 1942 72
Report of Committee on Awards for Scientific Exhibits 72
Report of Reference Committees: 73
Report of Reference Committee No. 1. On Reports of Officers and Standing Committees. By Chairman O'Neill 73
Items Discussed:
(a) Report on Hospitals 74
(b) Report of the Committee on Public Health Education: Basic Science 77
(c) Report of the Editorial Board 78
Report of Reference Committee No. 2. On Report of the Council and the Secretary-Treasurer. By Chairman Garland 80
Resolution of Council of Alameda County Medical Association.. 80
Report of Reference Committee No. 3. On Resolutions and Amendments to the Constitution and the By-Laws, and New and Miscellaneous Business 82
(a) Re: Payments for Medical Services 82
(b) Re: Survey California Medical Association, Legal Department 82
(c) Re: Conference with California State Federation of Labor 82
(d) Re: Pension Policy for Retired Employees 82
(e) Re: Hospitalization Subsidy 82
(f) Re: California Industrial Accident Commission Fee Schedules 82
(g) Medical Preparedness 83
(h) Re: Legal Department 83
(i) Re: Physicians' Benevolence Committee 84
(j) Re: Amendment to the By-Laws No. 1—Concerning Physicians' Benevolence Committee 84
(k) Re: Donation to Physicians' Benevolence Fund by Woman's Auxiliary 84
(l) Re: By-Laws Amendment Relating to Physicians' Benevolence Fund 85
(m) Re: Medical Service Rendered by Hospital Associations 85
(n) Re: Proposed Amendment No. 1 to Constitution.—State Association Dues to Members in Military Service. Adopted 85
(o) Re: Proposed Amendment No. 2 to Constitution.—On Manner in Which State Association Funds May be Raised. Adopted 85
(p) Re: Proposed Amendment No. 3 to Constitution.—On Terms of Office of Speaker and Vice-Speaker. Not Adopted 85
(q) Re: Proposed Amendment No. 4 to Constitution.—On Authority of Council to Contract with Hotel Managements. Adopted 86
(r) Re: Industrial Accident Code.—Objectionable Practices 86
(s) Re: Un-American Activities 86
(t) Re: Democracy in Organized Medicine 87
(u) Re: Rebating and Unethical Practices 87
(v) Re: New Resolution.—Shasta-Trinity County Medical Society 87
(w) Re: Un-American Activities (Reconsideration) 88
State Association Dues for 1943 89
Re: Budget for Year 1943 89
Introduction of Officers: President Molony; President-Elect Schaupp 89
Remarks by Retiring President Henry S. Rogers 89
Committee to Edit Minutes 90
Vote of Thanks 90
Adjournment 90